TOWN OF WELLESLEY

WORK RELATED INCIDENT REPORT

and

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To be filled out by Employee/Supervisor, signed by Employee and Supervisor, and submitted with 48 hours of incident.

Employee Name		Dept/Division	Social Security Number
Full Address			Telephone Number
Job Title		Date of Birth	Marital status (M or S)
Date of incident	Time of incident	Location of incident	
Date incident reported	To whom was incident reported? (name & job title)		Witness (name & job title)
Source of injury (tool, machine)		Type of injury	Body part(s)

Medical care required? Yes_____ No_____
If yes, name and address of medical care provider:

Describe what happened:

_____	_____	_____	_____
Employee signature	Date	Supervisor signature	Date

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

You, and any person associated with you, are hereby authorized to give, verbally or in writing, any and all information regarding my physical condition and treatment pertaining to _____ to the Town of Wellesley and/or its agents for insurance or occupational health purposes.

Employee signature_____ Date_____

Print name: _____

Address:_____

Send original of this form **with employee signature** to:

Department of Public Works	Director's Office, attn: Teresa Garcia, Secretary to the Director
School Department	Business Office, attn: Donna Kalinowski, Payroll Coordinator
Facilities Department	Administrative Offices, attn: Danielle Gariepy, Financial Analyst
All other departments	HR Department, Town Hall, attn: Joanne Liburd, Administrative Assistant